



Synapse



THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

Published Quarterly

Summer 2007 EDITION

Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

"YOUR DISTRICT BRANCH"

I have been the President of WHPS since May 2007. I have been active in WHPS before in membership/mentoring and then in Public Affairs as the Co-President of the Mental Health Coalition.

As I start my two-year term, I want to thank all the members of the Executive Council who have been involved with WHPS for several years. I also want to thank Dr. James Flax for all his efforts to "keep it going" for the last two years. I also want to welcome Dr. Mark Tarle who rejoined the Executive Board and will be in charge of the Ethics Committee.

In May of this year, I attended the APA assembly meeting in San Diego in lieu of Dr. Nigel Bark. It was a most interesting and intense experience. One was able to see different action papers being debated in smaller committees and then in area meetings before being voted upon by the entire assembly. The action papers were then passed onto the APA Board of Trustees for final resolution. The action papers have multifaceted subjects. Some examples include the protection of children who testify in criminal proceedings, psychotropics in the national stockpile, and use of the term suicidality.

I also attended an incoming President Elect's orientation. It was very interesting to see the challenges that we face in the WHPS are fairly similar to challenges in other District Branches. Our current challenges continue to be in maintaining our membership, increasing involvement in all or some of the District's activities. This can also involve

active feedback from our membership to give us leads in the ways that our District Branch can serve their needs. The District Branch is involved in several activities which involve advocacy for our patients, both at a local and state level, advocacy for our profession, networking with other psychiatrists and other mental health organizations throughout the country and building bridges with them.

At our last Executive Council meeting, the current activities of WHPS were discussed. Some of our activities are a monthly women's group meeting and a referral service, which continues to get three to four requests per week handled by Dr. Flax. We have also restarted the monthly private practice support group, which meets on once a month on Wednesday, 8-9am at the Nanuet Diner. Once again, the Mental Health Coalition had a very successful presentation at West Haverstraw Elementary School dealing with issues of divorce, transition to middle school, and family problems. Dr. Dominic Ferro and Dr. Diane DeGiacomo also gave a presentations to health classes all day at Tappan Zee High School regarding mental illness. Dr. Kroplick and Dr. Kelman are already planning our October meeting and are contacting potential speakers. Our Ethics Committee thankfully has nothing active to report. Our treasury is doing well especially with the grant money that Dr. Flax was able to acquire from the APA. Dr. Flax, Miss Rena Finkelstein from NAMI and some of us have also met with state senator Thomas Morahan in order to obtain another grant to support some of the activities of

the Mental Health Coalition. We will be able to give you more feedback regarding this in the next newsletter.

In the next two years I hope to start a dialogue

with clergy on the subject of mental illness, as well as have a workshop on depression in the workplace with the funds that we hopefully will acquire.

I am asking for the support of all our members for the array of activities described. Our executive meetings are open and any member can come to attend these meetings as a guest. I am eager to expand the Executive Board and anyone interested in joining it is welcome to do so. If you have interest please give me a call at (845) 362-2115. ▲



*Madhu Ahluwalia, MD,
President*

In This Issue...

- 2 Note Writing & Suicidal Patients
- 3 Electro-Convulsive Therapy
- 5 Report from Scotland
- 8 Edgar Allen Poe

Note Writing and Suicidal Patients

In the past, I have written articles in this column regarding various aspects of malpractice and report writing with regard to suicide assessment and have even included examples of suicide "scales" (for example, my Winter 2004 *Synapse* article). But a recent article in *Psychiatric Times* (by Christos Ballas, M.D., May 2007) is such a terrific on-point article regarding methods of documenting assessment and intervention with suicidal patients, that I thought I would

adapt another article from that one. The writer makes clear that the article is not about performing suicide assessments or an extensive description of the history and the physical of the suicidal patient. Rather, it focuses on the documentation of the information acquired, as well as reflections on your own thinking regarding the assessment, and plans for intervention with reasons for these interventions. One of the biggest mistakes highlighted, is spending too much time documenting objective signs and symptoms and not enough time in the assessment and planning for intervention. Describing your thought processes, which lead to conclusions about the patient and your interventions, is much more important than simply listing objective signs and symptoms. In essence, "You must write your assessment and plan in a way that makes it completely obvious to others why you did what you did."

A very common mistake, frequently made, is allowing the reader to infer whether the patient was suicidal or not simply by listing specific behaviors, actions or statements. For example, a statement like, "Patient denied suicidal ideations... was joking with staff... contracts for safety... may sound adequate and appropriate. Yet, that sentence requires the reader to make inferences, including what "denied suicidal ideations" and what "contracts for safety" means. Much is left out in that sentence. A much more appropriate sentence would include something like, "I was able to conclude that the patient wasn't suicidal because his responses, when asked about suicidality, were reasonable and appropriate (you might even include some of the responses), his affect was full, he was joking with staff, did not appear to present any of the vegetative signs of depression that he had presented previously (you might include some of those), and as a result, I concluded that he felt better, was improved, which reinforced my opinion that his prior suicidal ideas, which he currently denied, are no longer present."

In reviewing charts in malpractice cases, I often observed "check-off lists" regarding "appearance, speech, thought processes,

etc." While completing check-off lists may seem sufficient, it is much less valuable than a narrative description of the patient, future plans and other information documenting the patient's presentation.

Descriptions of the patient's comments, in quotes, are so much more valuable than a check-off list under a mental status listing. In essence, symptom assessment, while important to include in the note, is certainly less important than the diagnosis, dynamic formulation and your plans for intervention, with your reasoning for those interventions.

Another area which must be addressed, has to do with the timelessness of your assessment. Of course, a description of the reasoning for your assessment that the patient is not suicidal now, is important. But your notes should reflect some information about the future likelihood of the patient remaining non-suicidal, or that the patient may become suicidal again in the future, under certain circumstances. Thus, including in the note your description of the patient's future plans, the removal of certain stressors, the support system mobilized to help the patient, the change or increase of medication, the patient's thinking about the future, all are much more valuable in transmitting information about the high likelihood that the patient will not be suicidal in the near future.

On the other hand, if there is the possibility that the patient may very well become suicidal in the future, especially if the patient is still feeling hopeless and pessimistic, then that should be stated explicitly, as well, such as "However, given his history of impulsiveness/drug use/suicide attempts, it is probable that he will attempt suicide again at some point in his life when stressed. Unfortunately, this is a function of his future acute stressors, stressors over which I have no current control, not how he feels right now." In addition, meeting with and apprising family members of your



Executive Council

West Hudson
Psychiatric Society

- ▲ **PRESIDENT**
Madhu Ahluwalia, M.D.
- ▲ **PRESIDENT-ELECT**
Dominic Ferro, M.D.
- ▲ **SECRETARY**
Dominic Ferro, M.D.
- ▲ **TREASURER**
Alan Tuckman, M.D.
- ▲ **DELEGATE-TO-THE-ASSEMBLY**
Nigel Bark, M.D.
- ▲ **ALTERNATE DELEGATE:**
- ▲ **GOVERNMENT RELATIONS REPRESENTATIVE:**
- ▲ **LEGISLATIVE REPRESENTATIVE**
Andrew Hornstein, M.D.
- ▲ **MEMBERSHIP/MENTORING:**
Alan Tuckman, M.D.
- ▲ **PUBLIC AFFAIRS**
Diane DiGiacomo, M.D.
- ▲ **PUBLIC RELATIONS**
Richard Brand, M.D.
- ▲ **ETHICS COMMITTEE**
Marc Tarle, M.D.
- ▲ **EDUCATIONAL MATTERS**
Lois Kroplick, D.O., Jane Kelman, M.D.
- ▲ **PRIVATE PRACTICE REPRESENTATIVE**
James Flax, M.D.
- ▲ **DEPRESSION SCREENING**
Mona Begum, M.D., Mary Mavromatis., M.D.
- ▲ **WOMENS' COMMITTEE**
Lois Kroplick, D.O., Jane Kelman, M.D.
- ▲ **EARLY CAREER REPRESENTATIVE**
- ▲ **EDITOR, NEWSLETTER**
Robert Sobel, M.D.
- ▲ **CO-EDITOR, NEWSLETTER**
Syed Abdullah, M.D.

Telephone (845) 638-6992

Articles published in *Synapse* represent the views of their respective authors and do not necessarily represent the views of the West Hudson Psychiatric Society or its members.

Continued on page 4

Electro-Convulsive Therapy: How Does It Work? Is It Just Like Rebooting the Computer?



Introduction:

Electro-convulsive therapy (ECT) has been one of the effective somatic treatment options for mental illnesses for many years. We continue to face the public misperception about ECT and its effectiveness. The important task for all psychiatrists privileged in ECT is to tirelessly work to educate healthcare professionals, medical students, nursing students, patients, families, and the general public to overcome misperceptions about this treatment. In our ECT suite, I utilize every opportunity to educate our colleagues, direct care staff, auxiliary health care personnel, and nursing students about the history, methodology, therapeutic indications and effectiveness of ECT. Among the many questions asked of me, the ones often repeated are: "How does it work?" and "Why is it effective in psychiatric conditions?"

Analogy:

Still under investigation by clinicians as well as scientists is to understand how ECT works in mental illnesses. There continues to grow a body of scientific literature and research findings addressing this issue though the articles published sometimes contradict one another, the explanation for which may be due in part to limitations in methodology. There are several possible theories regarding ECT's mechanism of action. Among all the explanations put forth in publications of evidence-based medicine, the notion of cascaded hormonal reactions following a series of ECT treatments has been the most fascinating – at least for me.

One day, as I was sitting in my office and thinking about how I could effectively explain the mechanism of ECT to my students, an idea came to me. I was recalling my experience while working on the health sciences computer teaching staff as a faculty member of Public Health Sciences at New York Medical College prior to going onto psychiatric residency training. One of the commonly asked questions by some (computer naive)

students was: "What should I do when the computer is jammed with programs in RAM (random access memory) or is frozen? I remember simply stating: "Reboot the system". The computer will simply reload all necessary programs into RAM and again function properly. I was not suggesting that the computer needed to be rebooted every time, but letting the students know that there was a simple solution to clearing de-arranged computer programs in computer memory (RAM) when the computer was found not usable.

As I was thinking, I jumped out of my chair and realized that this might be a simple and reasonable analogy to use to explain ECT to my students. ECT may be to your brain what rebooting is to the computer's central processing unit.

What do we know?

For many decades, it has been known through evidence-based medicine that there are several hormonal changes and reactions in patients with depressive disorders, anxiety disorders, and psychotic disorders. Numerous investigators have documented high levels of plasma cortisol in depressed and anxious patients. In normal persons, the high level of cortisol is negative feedback to the central nervous system to suppress the release of corticotropin releasing hormone, and adrenocorticotrophic hormones (ACTH, Corticopropin) to maintain the body's homeostasis. In anxious and depressed patients, the negative feedback mechanism fails to function as it should resulting in persistently high cortisol level. However, most of the detected endocrine abnormalities return to normal baseline values when the psychiatric conditions (such as psychosis, depression, and anxiety) resolve or improve. Still today, it is not clear whether the deregulation of hormones is reflective of predisposing conditions (trait marker) or reflective of the illness (state marker).

Hypothalamo-Pituitary Axis (HPA) is a command center of bodily functions in humans as well as in other mammals.

Important hormonal axes related to HPA include adrenal hormones, thyroid hormone, growth hormone, prolactin, and sex hormones – among others.

Corticotropin releasing hormone from the hypothalamus regulates the release of adrenocorticotrophic hormone [ACTH] from anterior pituitary gland. ACTH, in turn, promotes the release of cortisol from adrenal cortex. Similarly, there are several stimulating hormones such as thyrotropin and gonadotropin that are involved in the release of corresponding hormones for their target organs. Growth hormone, prolactin, endorphin, and oxytocin responses are also included.

In anxious patients, there are several neuro-endocrine deregulations which include the adrenal, thyroid, and growth hormone axes. Also blunted release of thyrotropin, the thyroid stimulating hormone (TSH), and growth hormone (GH) from HPA are common in patients with mood disorders. Similar patterns of neuro-endocrine deregulation have been reported for schizophrenic patients in the scientific literature.

During treatment with ECT and after administering general anesthesia and a skeletal muscle relaxant, the patient is given a controlled stimulus to induce a seizure, which is clinically similar to a grand-mal seizure. There are cascades of hormonal changes following the ECT. By examining CSF and blood, before and after the treatment, different levels of changes for various hormones and their residues are demonstrable. Scientists and researchers have formulated a hypothesis for the association between hormonal changes and clinical improvements following ECT - though more complex analyses still need to be undertaken to demonstrate a direct causal relationship.

Continued on next page ➡

Electro-Convulsive Therapy, cont'd.

Hormonal changes following ECT

Hypothalamo-Pituitary Axis: ECT promotes the release of prolactin into the CSF and blood stream from the pituitary gland. Lisanby, et. al (1998) reported that prolactin release is a reliable marker of the ECT induced seizure and is responsive to both dose and electrode placements. Bilateral ECT releases more prolactin into the blood than does unilateral ECT. The prolactin release is not mediated by opioid receptor, alpha-adrenergic receptor, or serotonin-2 receptor mechanisms. Some investigators (Zis et. al, 1992) concluded that the effect on prolactin results from decreased tonic hypothalamic dopaminergic inhibition on the pituitary gland. More clinical studies are needed in order to better understand the correlation between ECT-induced prolactin release and the clinical antidepressant and antipsychotic effects of this treatment.

Hypothalamo-Thyroid Axis: The amount of thyrotropin released following ECT is not significant. Studies have reported that the amount released was less after the last session than after the first ECT treatment within a series of treatments, though this finding is not statistically significant (Cooper et. al, 1989). Scott, et. al. (1989), reported that ECT-induced thyroptopin release is not related to the anti-depressant action of ECT. The consensus is that thyrotropin-releasing hormone is not

significantly affected by ECT treatments (Whalley, et. al, 1982).

Hypothalamo-Adrenal Axis: By the late 1960s, it was established that mental illnesses, especially in anxious, depressed or psychotic patients, are associated with the elevated plasma cortisol levels. There were a number of studies that reported there are acute post-ictal increases in plasma levels of corticotropin and cortisol following ECT treatments. However, during the course of an ECT series, there is gradual reduction of basal and ECT-induced cortisol levels (not corticotrophin) (Whalley, et. al, 1982) as well as the cortisol response to exogenous corticotropin releasing factor (Dored, et. al, 1990). It has also been noted that the gradual lowering of plasma cortisol level is associated with improvement of depressive symptoms (Gibbson, et. al, 1962). ECT treatment may be disrupting the feedback mechanism of stress-induced elevated corticotrophin and cortisol levels and is associated with improvement of depressive states – also possibly of anxiety states.

Hypothelamo-Growth Hormone Axis: Growth hormone level is not affected by ECT, which is either unchanged or minimally reduced by the treatment (Yalow, et.al, 1969).

Hypothalamo-Gonadotropin Axis: The release of oxytocin, vasopressin, FSH, and LH hormones is not significantly correlated

to clinical improvement during a course of ECT treatments (Smith, et. al, 1994).

My thoughts:

ECT treatments clearly induce post-ictal releases of several important hormones needed for normal bodily functions. What happens after the release of these various hormones? I am sure that the brain replenishes them with fresh hormones in various axes and redresses any imbalance of tropic hormones in Hypothalamus axes – which in turn normalizes the body's homeostasis leading to physical and mental well-being.

My closing thoughts as I ponder these issues - "Is the mechanism akin to squeezing out excess water from soaked laundry?" or "Is it like rebooting a computer when it is jammed with overloaded programs or frozen?" "Is that the reason why ECT provides a quick clinical response, but short lived?" There are many questions to be answered. But I am pleased with my newly acquired analogy which I can use to simplify the explanation to my students as to how ECT works. ▲

Pe Shein Wynn, MD, MPH

Pe Shein Wynn, M.D., M.P.H. is a Director of ECT service at Rockland Psychiatric Center, Orangeburg, New York. The article is an author's formulation of analogy for mechanism of action, based on available data.

Suicidal Patients, cont'd.

thinking regarding the future risk, and including this in the note, is also extremely helpful. It makes clear that, while your assessment today concludes that the patient is not currently and, for the very near future suicidal, there are events in the patient's future which you have no control over and, if they occur, may again increase the patient's suicidal risk. You are also stating that the patient is not appropriate for hospitalization at present, despite the possibility of future suicidal ideation.

In addition, describing why it would be inappropriate to hospitalize the patient now, will also help you if the patient does make a suicide attempt in the future. As an example,

a note might state, "Hospitalizing the patient now is not going to alter that future eventuality and thus is not indicated today. In fact, recurrent hospitalization may be detrimental, because it seems to have established a pattern of dependency rather than finding better ways to deal with distress." You might also add something like, "I believe that the best way to help is to refer him for intensive therapy/day treatment for long-term follow-up, so he can have somewhere to go and someone to manage him as symptoms and stressors may develop. We even discussed a crisis plan for future suicidality, namely, at the first sign of distress he will call the doctor and if this is

not sufficient, he will then call the police. In addition, his wife will stay with him and if symptoms worsen, she will bring him to the emergency department."

Another recommendation, highlighted in the article, is that the report is "not a news (factual) article, it is an op-ed (opinion) piece." Thus, your sentences are personal and informal, explaining not only what you did, but why you did it.

In essence, your report emphasizes your judgment, and what you based your judgment on. "It should be obvious from the report exactly what you were thinking and

Continued on page 7 ➡

Report from Scotland

Since family functions prevented me from attending the Assembly this year, and I have just come from a very enjoyable and fulfilling meeting in Edinburgh, Scotland I thought I would write about that.

It was the Annual Meeting of the Royal College of Psychiatrists, the equivalent in Britain and Ireland of the APA though it also monitors and accredits training programs and conducts the qualifying ('membership') exams for psychiatrists. Compared with the APA it is an intimate affair: about a thousand people go and you can be sure of meeting them all because coffee, tea and cookies are available before the start and at mid-morning and mid-afternoon breaks and lunch is provided for everyone. Each morning and afternoon session starts with one 'plenary' lecture and the meeting then breaks into six concurrent meetings. And there are dinners and receptions each evening. I also attended business meetings of the six International Divisions that cover the world.

The theme of the conference was "Recovery", clearly a very fashionable concept in Britain as in some parts of the USA. "Recovery is seen as having at least three different meanings: as a spontaneous and natural process; as a response to effective treatments and as a way of growing with or despite continuing disability" and it is the latter that is receiving so much attention in Britain. But it is an "optimistic and inclusive... concept referring...to a particular and broad approach to the purposes and delivery of mental healthcare and to developing and sustaining vital partnerships between service users, their careers, professionals and managers at all levels that puts holistic patient centered approaches at its center."

As a skeptical and somewhat demoralized state hospital psychiatrist who saw the related ideas of prevention and concentration on health rather than psychopathology that embodied the Community Mental Health Centers thirty years ago lead to the neglect and exclusion of the severely mentally ill, I was suspicious. Even more so when I read "... recovery-based services emphasizes the personal qualities of staff as much as their

formal qualifications..." and remembered several disastrous times in the last 30 years when all members of a treatment team were asked to do the same things for patients, neglecting their special skills and experience. However this "Recovery" is clearly particularly concerned with the most severely ill and disabled; it embodies one idea I have always felt is very important: that people with schizophrenia should never be called or considered "schizophrenic" but son, wife, worker, painter, etc., who happens to have schizophrenia. And it does emphasize hope (and the need for clinicians to be the maintainers of hope during the worst times), resilience, empowerment, the importance of seeing and working with the positive - what the person can do - not what the person cannot - and the importance of consistent, long term therapeutic relationships. With our treatments so often disappointingly ineffective these are very important.

So we were reminded by Courtney Harding that all ten long term (20-30 years) follow up studies of schizophrenia showed recovery or remission in about 50% and the Vermont study with intensive rehabilitation of "back ward" patients achieved 65%; and that there has been no improvement in the long term outlook since the introduction of antipsychotics. A comparison of admissions 100 years ago and now at the Denbigh Asylum by Denis Healy showed an identical pattern of diagnoses and a significant and similar number of people with schizophrenia who recovered after about six months with fewer readmissions 100 years ago. Many of these may not need continuous medication and indeed may be worsened by it; the problem is we cannot predict which they are.

A review of 140 years of patients at Broadmore (the high security hospital for the criminally insane) by Harvey Gordon showed that most improved or recovered and were discharged within ten years, though some clearly did not.

Eve Johnstone gave a wonderful review of her 30 years of schizophrenia research starting at Northwick Park with Tim Crowe where she demonstrated clearly by CT scan the enlarged ventricles that had been suggested by early pneumoencephalography

studies but not confirmed because such studies were too dangerous for normal volunteers.

She went on in her Edinburgh high risk studies to show that

gray matter reduction and loss of gyration clearly predict schizophrenia, but are no use because no one has two scans when they are well. But the Val/Val alleles of the COMT gene do predict schizophrenia in at risk groups and the T/T alleles of the Neuroregulin gene predict all psychotic symptoms (and reduced premorbid IQ which correlates closely with gyration) but not specifically schizophrenia. And there is a very clear gradation of all measures from the controls through the high risk without symptoms, the high risk with symptoms to those with schizophrenia. We forget that thirty years ago her broad conclusions would not have been predicted: that schizophrenia is a brain disease, with an inherited vulnerability and biological support for diagnostic categories. Sadly, and surprisingly, there has been no significant advance in treatment in those 30 years.

Tim Crowe, who started the positive/negative studies with his 1980 paper oversaw a review of the 30 year work of the Medical Research Council's Northwick Park Center, which he directed. It confirmed the dopamine mechanism of antipsychotics with its 1978 flupenthixol isomer study (only one isomer was a dopamine antagonist), stimulated the neurodevelopmental hypothesis with the demonstration of childhood predictors (for example lower IQ) of schizophrenia in the National Child Development Cohort, showed that movement disorder may be part of schizophrenia and did major post mortem work on brains of patients who had been examined in great detail during life. Tim Crowe admitted that some of his hypotheses were designed to provoke and it was revealed that he was most upset that



Continued on next page ➡

Report from Scotland, cont'd.

their landmark study of sham ECT showed clearly that ECT worked – against his expectation.

Resilience was the topic in several sessions but it is certainly needed in Iraq. Dr Sabah Sadik, a psychiatrist who had worked in England for years went back and is trying to set up services there. Three years ago there were 150 psychiatrists in Iraq. Now there are 65. He arranged for ten to have special training to set up specialty services there. Only two have stayed. More hopeful is brief training of nurses and others who are somehow managing to see patients and provide some service and do a national survey of mental illness. He talked of the general problems of a long history of violent conflict, the “pride in history” which is so negative, the disastrous exodus of professionals and parliament behaving like a class of naughty children but with a much liked Prime Minister.

A report of students from Iraq showed that 25% to 50%, had PTSD – but 50% to 75% did not and about half were optimistic and half pessimistic about the future. And Sam Tyrano reported that in Israel Palestinian children have more PTSD than Israeli children but the rates in the Territories are much more, for example 10% severe, 56% moderate PTSD in the territories and 3% and 43% in Israel. The features associated with resilience were ideology and strong religious beliefs.

Simon Wessely reviewed responses to terrorism from the Blitz to Bin Laden. His review of contemporary documents from the second world war bombing of London showed that the resilience of Londoners was real, not a myth; that they did tolerate over 3000 civilian deaths a week for many months with humor and stoicism; that the provision of shelter and food and a true and factual daily presentation of the situation were essential. The only time the government lied – saying the V1 bombs were gas factory explosions no one believed it anyway.

He concluded from a review of controlled trials that psychological debriefing may make things worse. What appears to help is people talking about the disaster, to whom they want, when they want. The first thing everyone did after 9/11 and 7/7 (the

London Transport bombings) was to call their friends and relatives to check up on them. The lesson for New York, I think, as well as making sure the cell phone system works, is to make sure every child in school has a cell phone and carries it to school! (Are you reading this Mayor Bloomberg?)

Talking of terrorism Lord Alderdice, active member of the House of Lords, Speaker of the Northern Ireland Assembly, psychiatrist, psychoanalyst and active psychotherapist in Northern Ireland gave a wonderful overview of the situation there. He told how treating the “troubles” as only a law and order issue did not work; treating it as National Security and terrorism by bringing in the army did not work and suspending some civil liberties made it much worse. What worked was listening to the protagonists and getting them to talk to each other. He strongly encouraged psychiatrists to get involved in such conflicts because they have skills that can be helpful. When I asked him what had changed Ian Paisley he told how Ian Paisley spoke for a frightened and embittered people who had been sent to Ireland 300 years ago to defend Britain against “the enemy”, who had made enormous sacrifices for Britain in both World Wars and then been abandoned by Britain to “the enemy”. The other parties understanding this helped and in the Assembly although the protagonists had no respect for each other they did respect the Assembly and its parliamentary procedure and Lord Alderdice was able to cajole and humor them into being civil to each other. And of course Ian Paisley is getting old and has grandchildren and wants some peace and hope for them – and he wants to be remembered for that.

The session of the Pan-American Division (of the College) was on the law with a paper by Stephen Kiseley from Nova Scotia reviewing compulsory community treatment (AOT in New York) and finding no evidence that it helps. Sue Bailey gave a bleak picture of the treatment of children in England as criminals, with some hope from appeals to the European Civil Rights Commission.

Considering that so many policy documents from the British Government encourage ‘recovery’ and its associated ideas

mentioned above it is remarkable and sad that a new Mental Health Act for England introduced to Parliament eight years ago was so retrogressive and punitive – a response to a few highly publicized murders by people with mental illness. Anthony Zigmund, who almost by chance became the College’s parliamentary representative (lobbyist) gave a fascinating account of the Bill and its progress and of how he sat through every committee meeting and debate in the Lords and Commons and would write notes to be delivered to the opposition spokesman of points to oppose statements of the government. This bill led to the most active coalition ever in Britain of those concerned with mental health, including lawyers, to oppose the bill – and they have largely succeeded in making it a useful and helpful bill. For the first time in 800 years a bill was totally withdrawn and replaced because of public opposition – and this happened twice.

Finally an economics professor at the London School of Economics outlined his proposal for the Government to save an enormous amount of money by training 5000 people in cognitive therapy to treat depression and so reduce the loss of work depression causes!

Of course there was much more but that’s enough. Except I must report that the APA was very well represented with the current President and two former Presidents and several members of the Assembly and Board of Trustees and there were two Presidential Symposia on recovery and minorities and recovery and intellectual disabilities covering disparities in mental health care and trauma and resilience. The APA and Royal College had had joint symposia at the APA meeting in San Diego and are working together on other projects especially organizing psychiatrist volunteers to developing countries which has been a special interest of the College.

If you want to go to this meeting next year it’s in London. The registration fee is about 15 times that of the APA (they will not accept any contribution from the drug companies) but if you want to present you do not pay and in some circumstances you can get support for airfare and hotel. Anyone interested contact me. ▲

Nigel Bark, M.D.

Suicidal Patients, cont'd.

especially, that you were thinking that you took time to ask questions, observe, assess, and draw conclusions about the patient that were reasonable. You might have been wrong in your assessment but you did a thorough job." Your judgment, plan, reasoning and conclusions, should flow directly from your assessment of the patient's symptoms, as well as other factors, such as support system, losses, prior suicide attempts, etc. In Forensic Psychiatry, our reports follow what has come to be known as the "honorable four-fold path" (developed by Dr. Richard Rosner). This includes "psychiatric/legal question, legal basis, relevant clinical material and forensic psychiatric opinion or reasoning." We were taught repeatedly that the final section, forensic psychiatric opinion or reasoning, must flow from the first three. In the same way here, your reasoning must flow from the information you have accumulated, to the present time.

Another recommendation in the article, which may or may not be appropriate or

necessary is to add, in the assessment, that you also spoke with a significant other of the patient who agreed with your plan and was supportive in implementing it. As stated, it is one thing for you to say the patient is not suicidal and the future plan is appropriate, but it is tremendously helpful to have a family member tell you the same thing and agrees with your conclusions. Writing that down is extremely helpful. If a family member does not agree with you, you may still continue with your plan but you must describe your reasoning for continuing with your plan despite the disagreement of a family member.

If family members or friends are not available, at least document that you tried to make contact with them and you may even get a second clinician to evaluate the patient and concur with your plan. As the article states, "The standard of care, loosely defined, includes how a respectable minority of clinicians in your situation would have proceeded. Two doctors are usually

considered to be a respectable minority."

A final couple of suggestions include describing what you did for the patient that made him safer than he had been previously, and that you are convinced that the patient is not going to commit suicide in the very near future.

Always consider when writing these notes that, if a patient does commit suicide, you will not afterwards wish that you had included additional material in the note. Look at your notes as if the patient had committed suicide and you are pleased with your description of your reasoning and interventions (if not with the outcome). Finally, we must always keep in mind that while mistakes may occur or a bad outcome may result, we are only expected to meet the standard of care that other reasonable physicians in your position would meet. You don't have to be perfect. But you do have to describe in detail your assessment, interventions and reasoning. ▲

Alan J. Tuckman, M.D.

More than just medical malpractice insurance.

For 20 years, we've been the leader in medical malpractice insurance for psychiatrists and mental health professionals. You can depend on us to provide you with more than just insurance.

Our services include:

- Top-notch legal counsel with a proven track record
- Toll-free Risk Management Consultation Service (RMCS) helpline
- Complimentary risk management seminars
- *Rx for Risk* quarterly newsletter and risk management manuals
- Exclusive access to our Online Education Center (OEC)
- And, more!



Coverage for forensic psychiatric services and administrative defense benefits is included. Discounts available for groups, early career, child/adolescent, part-time, and moonlighting members-in-training.

Contact us and receive complimentary risk management tips designed specifically for psychiatrists.

The Psychiatrists' Program

(800) 245-3333, ext. 389

www.psychprogram.com

Edgar Allan Poe: His Take On a Mental Institution of His Times

I thought this would be an article that would bring some chuckle in these hot summer days. I have found that Poe was an interesting critic of literary and non-literary topics. There is no clinical significance to what he says. This piece was written after the humane treatment of Pinel was completed and the reforms in the mental health delivery were well established. Poe's role was to poke a little fun into the goings on. It is not a very well known article of the author who died at the young age of forty due to alcoholism, drugs, depression and attempted suicide intermittently. This is first part of a multi-part article, the remainder to appear in subsequent issues of Synapse.



Edgar Allan Poe was born in Boston in 1809. After a tumultuous life and a promising literary career, he died at the early age of forty. He was a poet, a short story teller, a master of the macabre and a critic of repute. He found employment in reputable journals and newspapers but was unable to hold these prestigious position for any length of time. He enrolled in the army but later contrived to drop out as the discipline was too much for his wildly restless life style and heavy drinking. Both his parents were stage actors and died early in his life. He was brought up by the wealthy family of Mr. John Allan. Over the years his relationship with the Allans soured into an unpredictable pattern of love and hate, acceptance and rejection. This contributed to the unstable life style of the young genius.

Edgar Allan Poe's acceptance by the American readers remained lukewarm and the publishers were for ever leery of investing in his writings. This led to much distress to the young writer as he sank deeper in debts and became more prone to heavy drinking. But his style was much appreciated in Europe and influenced many writers of short stories and poems. In Russia, France and Germany the short story carried a definite impact of Poe's style and substance.

Here I am presenting excerpts from this relatively little known short story of Poe. The subject is a private Mental Institution somewhere in the south of France. The story carries a chaotic medley of fact and fiction as well as a mixture of the satirical and grotesque narratives, and is titled:

The System of Doctor Tarr and Professor Fether

DURING the autumn of 18-- , while on a tour through the extreme southern provinces of France, my route led me within a few miles of a certain Maison de Sante or private mad-house, about which I had heard much in Paris from my medical friends. As I had never visited a place of the kind, I thought the opportunity too good to be lost; and so proposed to my travelling companion (a gentleman with whom I had made casual acquaintance a few days before) that we should turn aside, for an hour or so, and look

through the establishment. To this he objected -- pleading haste in the first place, and, in the second, a very usual horror at the sight of a lunatic. He begged me, however, not to let any mere courtesy towards himself interfere with the gratification of my curiosity, and said that he would ride on leisurely, so that I might overtake him during the day, or, at all events, during the next. As he bade me good-bye, I bethought me that there might be some difficulty in obtaining access to the premises, and mentioned my fears on this point. He replied that, in fact, unless I

had personal knowledge of the superintendent, Monsieur Maillard, or some credential in the way of a letter, a difficulty might be found to exist, as the regulations of these private mad-houses were more rigid than the public hospital laws. For himself, he added, he had, some years since, made the acquaintance of Maillard, and would so far assist me as to ride up to the door and introduce me; although his feelings on the subject of lunacy would not permit of his entering the house.

To be continued next issue...

SYNAPSE is available on the World Wide Web at <http://www.rfmh.org/whps>

SYNAPSE

PO Box 741

Pomona, NY 10970-0741



1992, 1999, 2000, 2001, 2003 and 2004 APA Newsletter of the Year Award • 1993 and 2003 APA Continuing Excellence Award • 1995 & 2002 APA Continuing Excellence Award • 1997 5 Year Continuing Excellence Award • 1998 APA Honorable Mention